New Jersey Department of Health and Senior Services
Emergency Medical Services
PO Box 360
Trenton, New Jersey 08625

Emergency Medical Technician Training Fund Continuing Education Course
Final Reimbursement Report

IDENTIFICATION

Course Sponsor	**Vendor Identification Number**	
Address	**County**	**Telephone Number**
City, State, Zip Code		
Contact Person	**Title**	
Course Number	**Volunteer Student Enrollment**	**Total Enrollment**

AGREEMENT

I certify that all information provided is accurate and in compliance with the Emergency Medical Training Fund P.L. 1992, c143 as amended and all related rules and regulations. I also agree to comply with all laws, rules and regulations governing the operations of the program.

I understand that if any violation of the law, rules and/or regulations governing the operation of this program are identified, that the institution may lose its accreditation status and be ineligible to receive funding .

No volunteer student may be charged a fee, nor may reimbursement from other sources be received for a volunteer student attending this course.

I agree to submit all documentation required by the "CEU Reimbursement Procedure/ Requirements."

I certify that I have read and understand all of the above statements.

Authorized Signature:_____ **Date:**_____

<u>NOTICE</u>: It is a crime for any person to knowingly or willfully provide false information on this application, or make deliberately misleading statements regarding the eligibility of applicants (NJSA 2C:21-4(a)).

DOH EMS Approval:_____ **Date:**_____